MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08223

8228

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH: COUNTY Worcester MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 60

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Whaleyville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) Margaret (Middle) Elizabeth (Last) Armstrong

4. DATE OF DEATH: (Month) Aug. (Day) 9 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: July 7, 1915

9. AGE Last birthday 40 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Edward Mumford.

14. MOTHER'S MAIDEN NAME: Lalder Showell.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-12-3602

17. INFORMANT & ADDRESS: Isaac Armstrong Whaleyville

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X

IMMEDIATE CAUSE (A) Cancer of the uterus with

ANTECEDENT CAUSE (S) DUE TO widespread metastasis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH 18-24 mos.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/29, 1955, to 8/8, 1955, that I last saw the deceased alive on 8/8, 1955, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE Leon M. Purdy Jr. M. D. ADDRESS Berlin Md DATE SIGNED 8-10-1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial; DATE THEREOF 8/12/55; NAME OF CEMETERY OR CREMATORY Pulletts Chapel; LOCATION (City, town, or county) (State) Whaleyville, Md.

DATE REC'D BY LOCAL REGISTRAR 8/10/55; REGISTRAR'S SIGNATURE Helen F Hayward

24. FUNERAL DIRECTOR Peter Whaley ADDRESS Selbyville, Del.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 8231

8227 CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke
TOWN 3-Fourth Street
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home
LENGTH OF STAY (in this place) 42

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN 3-Fourth Street 42
STREET ADDRESS (If rural give location) Pocomoke City, Maryland

3. NAME OF DECEASED: (First) John (Middle) Henry (Last) Colbourn
4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M.	C.	Married	Oct. 24, 1893	61 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John S. Colbourn
14. MOTHER'S MAIDEN NAME: Georgia Anna Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 213-01-7224
17. INFORMANT & ADDRESS: Nettie Colbourn, Pocomoke City, Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
162X Immediate cause	(a) Exhaustion & Malnutrition	2½ mths
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Bronchogenic Carcinoma.	2 yrs.
	DUE TO (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cystitis.	

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/5/55, to 8/30/55, that I last saw the deceased alive on 8/30/55, and that death occurred at 3:15 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) Cecil A. Downey.
ADDRESS 508 Fifth St Pocomoke
DATE SIGNED 9/1/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/2/55
NAME OF CEMETERY OR CREMATORY Greenlawn, Cem.
LOCATION (City, town, or county) Berlin, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 2, 1955
REGISTRAR'S SIGNATURE Anne E. White
24. FUNERAL DIRECTOR Edgar Nelson
ADDRESS Berlin, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08233

! 8229

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH: COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke, Md. X
STREET ADDRESS (If rural give location) R.F.D. 1

3. NAME OF DECEASED: (First) LOWELL (Middle) (Last) FOUNTAIN

4. DATE OF DEATH: (Month) August (Day) 16 (Year) 1955

5. SEX: male

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: April 1, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months 4 Days 15 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fountain

14. MOTHER'S MAIDEN NAME: Annie Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)

17. INFORMANT & ADDRESS: Annie Marshall - Pocomoke, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
571.0 IMMEDIATE CAUSE	(A) Exhaustion & Dehydration	4 days
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Acute Gastro enteritis DUE TO	15 dys
	(C) Hydrocephalus (spastic)	4½ mths.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Cerebral Palsy (Spastic)	4½ mths

19A. DATE OF OPERATION: 6-7 April '55

19B. MAJOR FINDINGS OF OPERATION: Hydrocephalus (internal)

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/2, 19 55, to 8/13, 19 55, that I last saw the deceased alive on 8/13, 19 55, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Cecil A. Downey M. D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-17-55	R.B. Wharton Memorial	Parksley Va.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 20, 1955	Anne E. White	Edgar Wharton	New Church, Va.

9U45 93V 49V

VS A(15)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that th[illegible]h certificate be executed within [illegible] page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: R. F. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LOUISE Middle: GENETTA Last: GRIFFIN

4. DATE OF DEATH: Month: AUG. Day: 21 Year: 1955

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 4, 1891

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JESSE TURNER

14. MOTHER'S MAIDEN NAME: ELLA TOWNSEND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Address: MR. LEE GRIFFIN, BERLIN, MD. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Severe Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Operation for Removal Ca of Colon May 1955

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1942 to August 21, 1955 that I last saw the deceased alive on Aug 21, 1955, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hernando Tarkus M.D. ADDRESS (Street, city or town, state): Berlin, Md DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: AUG. 24 1955

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Truman A. Burbage ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: APR 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Pusey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08234

8230 CERTIFICATE OF DEATH Reg. Dist. No. 353

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop R7D. LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
STREET ADDRESS (If rural, give location) R7D.

3. NAME OF DECEASED: (Type or Print) (First) Stella (Middle) Mae (Last) Dickerson

4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: Wh | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: April 27 | 9. AGE last birthday: 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY: own Home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Tubbs | 14. MOTHER'S MAIDEN NAME: Mary Lueller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — | (If Yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT & ADDRESS: Mr. Joseph Dickerson R7D Bishop Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260X
IMMEDIATE CAUSE (A) Coronary atherosclerosis, acute pulmonary congestion 2 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) arteriosclerosis severe, diabetes gangrene 1 year
DUE TO (C) diabetes mellitus 15 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. old ununited hip fracture 1 year

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1954, to Aug., 1955, that I last saw the deceased alive on ....., 19..., and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Robert A. Gentz MD | ADDRESS M. D. Berlin, Md. | DATE SIGNED 8/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/14/55 | NAME OF CEMETERY OR CREMATORY Zion Church yard | LOCATION (City, town, or county) (State) Bishopville, Md.

DATE RECD BY LOCAL REGISTRAR 8/13/55 | REGISTRAR'S SIGNATURE Mrs. D. Ray Burgess | 24. FUNERAL DIRECTOR Peter Whaley | ADDRESS Selbyville Del.

VS. A15—10.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08235

CERTIFICATE OF DEATH

8231

Reg. Dist. No. 353

1. PLACE OF DEATH: COUNTY Worcester MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bishopville; STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (First) Laura (Middle) E. (Last) Hudson

4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1955

5. SEX: Female; 6. COLOR OR RACE: White; 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow

8. DATE OF BIRTH: Nov. 4, 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Caleb Lynch

14. MOTHER'S MAIDEN NAME: Julia Brocum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs H.B. Morris Bishopville Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X

IMMEDIATE CAUSE (A) Pulmonary edema acute — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (B) DUE TO (B) Cor pulmonale (pulmonary emphysema) — 2 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) severe asthmatic bronchitis — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. resultant Emphysema

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept ..., 1953 to Aug ..., 1955, that I last saw the deceased alive on August 10, 1955, and that death occurred at 4 A. M, from the causes and on the date stated above.

SIGNATURE Robert A. Grubb MD M. D. | ADDRESS Berlin, Md. | DATE SIGNED 8/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/13/55 | NAME OF CEMETERY OR CREMATORY I.O.O.F. | LOCATION (City, town, or county) (State) Bishopville Md.

DATE REC'D BY LOCAL REGISTRAR 8/12/55 | REGISTRAR'S SIGNATURE Mrs L. Ray Bergey | 24. FUNERAL DIRECTOR Peter Healey | ADDRESS Salisbury Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08236

8232 **CERTIFICATE OF DEATH** Reg. Dist. No. 351

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Worcester; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill; MARYLAND; LENGTH OF STAY (in this place) 44 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) (Last) Hudson

4. DATE OF DEATH: (Month) Aug (Day) 9 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: April 16-1911

9. AGE last birthday: 44/3/33 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Mins.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Hatchery

11. BIRTHPLACE (State or foreign country): Snow Hill

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William J. Hudson

14. MOTHER'S MAIDEN NAME: Emma Rodney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 220-26-2819

17. INFORMANT & ADDRESS: Mrs Mary L Townsend, Snow Hill Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) DUE TO: Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 20, 1955, to Aug. 9, 1955, that I last saw the deceased alive on Aug. 9, 1955 and that death occurred at 8 30 P M, from the causes and on the date stated above.

SIGNATURE Thomas L. Jones, M.D. M. D. ADDRESS Snow Hill, Md. DATE SIGNED August 10 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial DATE THEREOF: Aug 12/55 NAME OF CEMETERY OR CREMATORY: Episcopal Cemetery LOCATION (City, town, or county): Snow Hill (State): Md

DATE REC'D BY LOCAL REGISTRAR: Aug 12 1955 REGISTRAR'S SIGNATURE: Emmyn L. Cooper 24. FUNERAL DIRECTOR: Elmer E. Timmis ADDRESS: Snow Hill, Md

VS. A15 — 10 —

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08237

8233

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH.
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) (Last) Marshall

4. DATE OF DEATH (Month) Aug. (Day) 29 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH: Nov. 15 - 1885
9. AGE last birthday 69/9/14 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country): Worcester Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ira Jones
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT & ADDRESS Mr James E. Baxter, Snow Hill, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

44 X

IMMEDIATE CAUSE (A) Cerebral Vascular Accident — 2 days

ANTECEDENT CAUSE (S) DUE TO (B) Hypertension Cardiovascular disease — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 1955, to Aug. 29., 1955, that I last saw the deceased alive on Aug. 29, 1955 and that death occurred at 1:00 PM, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Snow Hill DATE SIGNED 8-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 1/55
NAME OF CEMETERY OR CREMATORY Baptist Cemetery
LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept 1, 55
REGISTRAR'S SIGNATURE Elwyn E. Cooper
24. FUNERAL DIRECTOR Alley E. Simmons ADDRESS Snow Hill, Md

8234

08238

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 355

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
LENGTH OF STAY (In this place) 3 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Dover
STREET ADDRESS (If rural, give location) Dover-Hartley Road

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROWE	VON PLEASANTON		AUG. 11 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	APRIL 3, 1904	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
ROAD CONSTRUCTION CONT.	SOLE-EMP.	DOVER DEL.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
JAMES PLEASANTON	MARTHA THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	–	MRS. R. V. PLEASANTON, DOVER DEL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause 4.20.1	(a) Acute Coronary Thrombosis	minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Coronary Atherosclerosis & Coronary Heart Disease	2 yrs.
	(c) DUE TO Coronary Thrombosis - Hemorrhage	120 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Herman A. Robbins M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ DATE SIGNED 8/17/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/15/55	Lakeside	Dover Del

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-13-55	Helen T. Hayward	Emma A. Burbage	Berlin Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A-5-55

8235

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 08239

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 351

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
LENGTH OF STAY (In this place) 2yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural #2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location) Rural #2

3. NAME OF DECEASED: (Type or Print) (First) Barbara (Middle) a. (Last) Shackley
4. DATE OF DEATH (Month) Aug (Day) 9 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Nov. 4 1932
9. AGE last birthday: 2/9/5 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Salisbury
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Avery Shackley
14. MOTHER'S MAIDEN NAME: Lottie Copeland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mr Thomas Copeland, Snow Hill, Md Rural #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Asphyxiation — Interval between onset and death: 10 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO (b) Bilateral Confluent Bronchopneumonia with purulent Bronchitis — 2 days

4917

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Robert W. LaMar M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 8-10-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF Aug. 11 55 NAME OF CEMETERY OR CREMATORY Pitts Chapel LOCATION (City, town or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REG. Aug 11, 55 REGISTRAR'S SIGNATURE Elmer E. Cooper 24. FUNERAL DIRECTOR Elias E. Timmis ADDRESS Snow Hill, Md

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 350

1. PLACE OF DEATH: COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City (Rural) | LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jones Farm 3 miles of Pocomoke

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural — Pocomoke City Md
STREET ADDRESS (If rural, give location) 3 acres road from Pocomoke to good-will

3. NAME OF DECEASED: (Type or Print) (First) Henry (Middle) (Last) Taylor

4. DATE OF DEATH (Month) Aug (Day) 22 (Year) 1955

5. SEX: M | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S | 8. DATE OF BIRTH: (Mo.—Day) Dk (Year) 1882 | 9. AGE last birthday: 73 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Farm | 11. BIRTHPLACE (State or foreign country): Dont Know | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Levin Taylor | 14. MOTHER'S MAIDEN NAME: Mary Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | 16. SOCIAL SECURITY No.: None | 17. INFORMANT & ADDRESS: Sister Rose L. Taylor Stockton Md R.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Regina Fractoris	DUE TO	Short
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (stating underlying cause last)	(b) Coronary disease	DUE TO	3 years +
	(c)		

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Performed heavy work for 2 or 3 hrs before death

19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE M. E. Bartosino M. D. | CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ | DATE SIGNED 8/27/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 8-27-55 | NAME OF CEMETERY OR CREMATORY Pt. T. Hope | LOCATION (City, town, or county) Pocomoke (State) Md

DATE RECD BY LOCAL REG. Sept 2, 1955 | REGISTRAR'S SIGNATURE Anne E. White | 24. FUNERAL DIRECTOR Edgar Wharton — New Church Va. | ADDRESS

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24 hours after death.